A complaint survey was conducted at the facility from October 24, 2018 through October 25, 2018. The facility was found in substantial compliance with 42 CFR 483.

The surveyors conducting the survey were:

Jenny Walker, RN Team Leader
Susette Mace, RN
May 17, 2019

James Hayes, Administrator
Payette Center
1019 Third Avenue South
Payette, ID 83661-2832

Provider #: 135015

Dear Mr. Hayes:

On October 24, 2018 through October 25, 2018, an unannounced on-site complaint survey was conducted at Payette Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007879**

Allegation #1:

The facility refused to transfer a resident to the hospital and the family had to call an ambulance to take them.

Findings #1:

During the survey eight resident records were reviewed, observations were conducted, and residents and family were interviewed.

Resident interviews were conducted to determine if they were allowed their choice of physician, and if they had any delay in treatment. All resident interviews revealed no issues with the facility services and treatment. Family interview of a current resident's family revealed no issues to report.
One resident's record included documentation the responsible party for the resident signed the transfer of physician services to the facility Medical Director to provide care upon admission on 6/9/18.

The resident's record included a Progress Note which documented the resident's daughter approached a nurse at 11:25 AM and stated she wanted the resident transferred to ER for evaluation for dehydration, mental status change, and an x-ray. The staff prepared the paperwork for transfer, a transport arrangement was made for the resident at 11:45 AM and the resident's transport arrived at 11:50 AM.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #2:

The facility failed to follow up on treatment for a Urinary Tract Infection (UTI) in a timely manner.

Findings #2:

During the survey five resident records were reviewed for infections and medications, six residents were reviewed for changes in bladder function, and observations were conducted.

One resident was admitted to the facility with a chronic UTI and urinary incontinence. The resident received antibiotic therapy. Review of the medication administration record (MAR) documented the admission order was completed and all antibiotics were administered. The resident was also on a prophylaxis antibiotic to prevent reoccurrence of UTI's, which was also administered as ordered.

The resident's physician was notified of a preliminary laboratory report related to a urine Culture & Sensitivity, but chose to wait on the full Culture & Sensitivity report to ensure the resident was started on the antibiotic medication that was effective for the specific organism. Upon receipt of the test results the physician prescribed the antibiotic specific to the organism identified for treatment of the UTI for the resident. Review of the MAR revealed staff provided the medication as ordered.

Observation of incontinence care of residents revealed no issue with the provision of care and no issue with infection control. General observation during the survey revealed no identified infection control issues by staff providing resident care.
There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

Staff were rough when assisting residents which resulted in bruising.

Findings #3:

During the survey eight resident records were reviewed, facility incident reports were reviewed, facility grievances were reviewed, staff personnel files were reviewed, and observations were conducted.

Personnel files for staff were reviewed. The facility did background checks and provided abuse training which was appropriate to all staff. There was no documentation in the personnel files of substantiated abuse by staff.

Review of facility incident reports from June 2018 through October 2018 did not include reports of rough treatment or abuse by staff to residents. Review of additional incident reports involving a bruise on a resident documented the facility investigated and concluded bruising was not related to abuse or neglect by staff. Review of grievances for the facility for the past 6 months did not include documentation of complaints of bruising due to rough treatment by staff.

One resident was observed while being transferred by two staff using a mechanical lift. There were no concerns identified during the observation.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.
If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj